SYRINGE EXCHANGE SEMI-ANNUAL REPORT

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF DISEASE CONTROL
SFN xxxxx (7-2017)

Agency Information

Agency Name	*Telephone Number*	*Reporting Quarter*
Agency Contact	*Email Address*	
Physical Address	*City*	*Zip*

Event Totals

Number of Participants of Participants Serviced	*Number of New Participants in the Quarter*
Approximate Number of Syringes Collected	*Number of Syringes Distributed*
Number of Individuals Referred to Testing Services	*Number of Individuals Receiving Testing Services*
Number of Individuals Who Received Education	*Number of Doses of Naloxone Distributed*
Number of Condoms Distributed	*Number of Individuals Referred to Treatment Services*

Demographic Information—Please report on deduplicated clients served in the reporting period

Gender: _____ Male _____ Female _____Trans MTF *_____ Trans FTM _____ Other _____ Unknown* *_____ Declined*	*Race: _____ Black/AA _____ White _____ AI/AN* *_____ Asian _____ Native Hawaiian/PI* *_____ Other _____ Multi-Racial* *_____ Unknown _____ Declined*
Current Living Status: _____ Permanent Residence *_____ Car/Vehicle _____ Homeless _____ Shelter* *_____ Declined _____Other*	*Ethnicity: _____ Hispanic/Latino _____ Not Hispanic/Latino* *_____ Unknown _____ Declined*
Number of Clients by County of Residence *County: _____ Number: _____* *County: _____ Number: _____* *County: _____ Number: _____* *County: _____ Number: _____* *County: _____ Number: _____*	*Substances Used within Last 30 Days: (can be multiple per person)* *_____ Heroin _____ Methamphetamine/Speed* *_____ Crack/Cocaine _____ Methadone (not as prescribed)* *_____ Saboxone/Subotex (not as prescribed)* *_____ Prescription Pain Medication (not as prescribed)* *(codeine, Vicodin, OxyContin, Hydrocodone, Percocet, Fentanyl, etc.)* *_____ Cannabis/Marijuana _____ Spice _____ Alcohol* *_____ Benzodiazepines (Benzos, Ativan, Xanax, etc.)* *_____ Other*

Progress Report

Please enter your sites goals and objectives that were submitted as part of your application process.

Objective	*Target*	*Current Progress*	*Progress Narrative*

Report To: This report is to be submitted 15 days after the previous reporting period to remain in compliance with reporting requirements. Failure to do so may result in termination of authorization of the program.

January 1 – June 30 Due: July 15
July 1 – December 31 Due: January 15 of the next year

Email: disease@nd.gov
Fax: 701.328.2499

Reminder: Do not include any personally identifying information on this form